Received Letter to Administrator 9/19/06

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	295077	A. BUILDING _____ B. WING _____	08/17/2006

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
REGENT CARE CENTER OF RENO	555 HAMMILL LANE RENO, NV 89511

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the annual Medicare re-certification survey conducted at your facility on 8/14-8/17/06. The census at the time of the survey was 139. The sample size was 25. Two complaints were investigated during the survey. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. Complaint #NV00012262 was an entity reported incident of verbal abuse toward a resident by staff. The incident was substantiated, but no citation was issued due to the actions of the facility. Complaint #NV00012597 was an entity reported incident of a resident's complaint of verbal abuse and excessive roughness during care. The incident could not be substantiated, however, a deficiency was cited at Tag 309 for an unrelated issue.	F 000		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced	F 309	*Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth on the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law.*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

[signature] | Admin | 09-08-

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

SEP 12 2006

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F 309	Continued From page 1 by: Based on observation, record review, and interview, it was determined that the facility failed to assess, evaluate and provide the necessary care to maintain the highest psychological and/or physical well being for 2 or 25 residents. (Residents #14 and #25) Findings include: Resident #14: The resident was admitted on 5/24/06 with a readmission on 7/12/06 after an acute care stay. Diagnoses included edema, malaise, dementia, hypertension, depression, renal failure, and a history of a cerebral vascular accident with hemiplegia. Resident #14 was receiving Haldol (an antipsychotic) as needed for agitation and Ativan (a short acting Benzodiazepine) as needed for anxiety. It was noted that the monitoring of the behaviors was documented on the Medication Administration Record (MAR). The entries stated "monitor for # (number) episodes of sleeplessness and monitor for # (number) episodes yelling, increased restlessness." It was not specific as to what behaviors indicated anxiety versus agitation. There were no indicators of non medical interventions or approaches or a place to document the effectiveness of the intervention. Review of the MAR revealed that Resident #14 received doses of both Haldol and Ativan on 7/19/06, but no behaviors were documented for that date. On 7/20/06, both Ativan and Haldol were administered without any documentation, on the monitor line, of behaviors occurring, as well as documentation of the as needed medications	F 309	**F309** Each Resident must receive and the Facility must provide the necessary care and services to attain and maintain the highest practicable physical, mental, and psychosocial well being, in accordance with the comprehensive assessment and plan of care. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice:** Resident #14. Resident's documentations were clarified to specify anxiety versus agitation behavior. Behavior monitoring record/form revised to include the interventions attempted and its effectiveness. Psyche consult ordered to assess Resident's psyche needs. Resident #25. Unable to correct since incident already occurred. **How you will identify other residents having the potential to be affected by the same practice and what anticipated corrective action will be taken:** All residents have the potential to be affected by the practice.	

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F 309	Continued From page 2 being given on 7/21/06, 7/25/06, 7/27/06, and 7/28/06. The back of the MAR did indicate under "Nurses Notes" that Haldol was given on 7/21/06 for " got agitated and anxious" and that it was helpful, that both Haldol and Ativan were given for restlessness on 7/25/06 and that it was effective, and that Haldol and Ativan were given for restlessness on 7/27/06 and that it was effective. The care plan for altered cognitive function and thought process for Resident #14 was reviewed. The care plan was initially dated 7/12/06 with a revision and update indicated on 7/21/06. Approaches included remove from stimulating environment, provide reassurance and support, engage in activities during the day to encourage sleep at night, determine reason for altered thought processes, discuss feelings, and allow for verbalization of feelings. The chemical restraint assessment for Resident #14 dated 7/12/06, indicated alternative approaches to the restraint program included setting limits to negative behavior, 1:1 approach, frequent reminders, close monitoring, re-orientation, redirection, assign tasks, and provide a calm environment and TV. Review of the nurses notes for the dates of 7/19/06, 7/21/06, 7/25/06, 7/27/06, or 7/28/06 failed to reveal documentation of any of the stated approaches being utilized prior to the medication being administered to Resident #14. In an interview with the Director of Nurses at 12:30 PM on 8/15/06, she stated that there was no written documentation of behavioral monitoring that would include the interventions attempted, effectiveness of the interventions, or the increase or decrease in behaviors. She further stated that	F 309	**What measure will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** Staff in-service scheduled on September 15, 2006 and on-going, to review Pain Management Policy (see Attachment A); Chemical Restraint Protocol and Review on the Revised Behavior Monitoring Forms. **How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur:** DON and/or designee will conduct an on-going regular review/audit on behavior documentation. Don and/or designee will conduct a random audit and interview Residents on Pain Management. 1:1 in-service will be done as indicated. **Individual Responsible:** Director of Nursing **Date of Completion** September 15, 2006	09-15-06 09-15-06

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F 309	Continued From page 3 the information was gathered each day in a verbal report and that the resident was then discussed in a interdisciplinary meeting. There was no indication that Resident #14 had been involved in the interdisciplinary process as of the date of the survey. There was no evidence that possible reasons for the resident's distress had been considered and ruled out, that there had been any changes in her behaviors, or if any of the interventions had been effective. Each day of the survey, Resident #14 was observed to have behaviors of crying uncontrollably, yelling out to passersby, "Don't leave me," or grabbing people by the arm as they passed by. The most current Minimum Data Set (MDS) described the resident as being severely impaired in cognitive function and decision making and having altered awareness, crying, disorganized speech and restlessness. Resident #25: The resident was admitted to the facility on 7/21/06, with diagnoses including cerebrovascular accident with left hemiparesis, hypertension, osteoporosis, depressive disorder, lumbago and hypothyroidism. The facility provided an incident report dated 8/15/06, to the survey team on 8/16/06. The incident form indicated that Resident #25 complained that the CNA (Certified Nursing Assistant) was rude and had bent her leg too hard and causing pain. The report also indicated that the CNA reported the resident's pain to the nurse following a 12:45 AM pad change. Record review revealed that Resident #25 had neuropathic pain on the left side of her body due to a cerebrovascular accident. She was ordered	F 309	PLEASE SEE PAGES 2 AND 3	9-15-06

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F 309	Continued From page 4 Vicodin ES every six hours, as needed, for moderate to severe pain. Tylenol was also ordered every four hours, as needed, for pain. Her medication administration records indicated that the resident did not receive any pain medication during the night shift on 8/15/06 after complaining of pain. The resident's last documented pain medication had been administered on 8/14/06 at 6:00 AM. The Licensed Practical Nurse, who was in charge when the incident occurred, was interviewed on 8/17/06, at 10:45 AM. He stated he was not aware of the resident's pain until he visited the resident's room sometime after 3:00 AM. He stated that Resident #25 reported that the CNA had hurt her leg during care. He reported the resident stated she was in pain. He was asked why the resident had not received medication for pain after her direct complaint of pain to him. He stated that the resident had refused pain medication. There was no documentation found in the resident's records to indicate that the nurse had assessed the resident's leg and complaint of pain as indicated in her plan of care. There was no documentation found to explain why Resident #25 had refused to accept pain medication following her complaint. Although her MDS indicated she had short term memory loss, Resident #25 was able to state that she had pain on the night of the incident when interviewed on 8/17/06. Review of the record revealed that Resident #25 did receive pain medication from the day shift nurse at 7:00 AM on 8/15/06.	F 309	PLEASE SEE PAGES 2 AND 3	9-13-06